



State of California-Health and Human Services Agency
Department of Health Services



DIANA M. BONTA, R.N., Dr. P.H.
Director

ARNOLD SCHWARZENEGGER
Governor

December 15, 2003

CHDP Program Letter No.: 03-32

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP)
PROGRAM DIRECTORS, DEPUTY DIRECTORS, STATE CHILDREN'S
MEDICAL SERVICES (CMS) BRANCH STAFF AND REGIONAL OFFICE
STAFF

SUBJECT: ADMINISTRATIVE EXPENDITURE INVOICES FOR THE HEALTH CARE
PROGRAM FOR CHILDREN IN FOSTER CARE (HPCFC)
ADMINISTRATIVE BUDGET AND THE CHILD HEALTH AND
DISABILITY PREVENTION (CHDP) PROGRAM FOSTER CARE
ADMINISTRATIVE BUDGET (COUNTY/CITY MATCH)

The purpose of the CHDP Program Letter is to provide local CHDP Program staff with quarterly administrative expenditure invoice preparation instructions and forms for the Fiscal Year (FY) 2003-2004 Health Care Program for Children in Foster Care (HPCFC) and the CHDP Foster Care (county/city match) administrative budgets. The invoice preparation instructions and forms have changed and are included as attachments to this letter. Copies of the invoice forms may also be obtained from the Children's Medical Services Branch web site www.dhs.ca.gov/pcfh/cms/pfg.htm. Please print and insert these instructions into Section 8, Expenditure Claims and Equipment Management, of the CMS Branch Plan and Fiscal Guidelines Manual (PFGM) until such time as the information in this letter be included in revision to the PFGM.

Quarterly administrative expenditure invoices authorized in HPCFC Administrative Budget (No county/city match) and the CHDP Foster Care Administrative Budget (county/city match) are to be submitted no later than 60 days after the end of each quarter.

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ADDRESS FOR THE SUBMISSION OF HCPCFC AND CHDP FOSTER CARE
QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICES:

Children's Medical Services Branch
Program Support Section
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413
ATTENTION: Fiscal Unit

If you have any questions or need additional information, please contact your Regional
Administrative Consultant.

Original Signed By Maridee A. Gregory, M.D.

Maridee A. Gregory, M.D., Chief
Children's Medical Services Branch

Enclosures

**Health Care Program for Children in Foster Care
Quarterly Administrative Expenditure Invoice
(No County/City Match) Instructions**

In order to receive reimbursement for Health Care Program for Children in Foster Care (HCPCFC) expenditures, the Quarterly HCPCFC Administrative Expenditure Invoice must be prepared in accordance with the following instructions. A sample HCPCFC Quarterly Administrative Expenditure Invoice form is included.

The HCPCFC Quarterly Administrative Expenditure Invoice (No County/City Match) instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the Invoice form. Local county and city Child Health and Disability Prevention Programs administering the HCPCFC are reimbursed for the actual administrative costs according to the amount of State General Funds and Federal Funds (Title XIX) on the invoice form. General information about Children's Medical Services Quarterly Administrative Invoices is on page 235, Section 6, Plan and Fiscal Guidelines Manual.

A. Category/Line Item

1. Total Personnel Expense (see I. Total Personnel Expense on the invoice form.)

Enter the total amount of Personnel Expense for the quarter in Column 1. This is the total expenditure for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

Enter the total amount of state and federal funds at the enhanced percentage in Column 2.

Enter the total amount of state and federal funds at the non-enhanced percentage in Column 3.

The amount of enhanced and non-enhanced percentages is calculated using completed time study documents and other applicable documentation.

The Total Invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

2. Total Operating Expense (see II. Total Operating Expense on the Invoice form.)

Enter the total amount of state and federal funds for the quarter in Column 1.

Enter the total amount of enhanced travel and training expense in Column 2.

Enter the non-enhanced travel and training expense in Column 3.

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The Total Invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

NOTE: Only travel and training expenses may qualify in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. Total Capital Expense (see the shaded area III. Total Capital Expense on the Invoice form.)

Total capital expenses are not allowed on the HCPCFC Administrative Budget.

4. Total Indirect Expense (see IV. Total Indirect Expense on the Invoice form.)

Indirect expenses are non-enhanced, they may not be claimed at the enhanced rate.

Enter the total of internal indirect expenses for the quarter in Columns 1 and 3.

The Total Invoiced amount in Column 1 is the same as the amount in Column 3.

5. Total Other Expense (see the shaded area V. Total Other Expense on the Invoice form.)

Total other expenses are not allowed on the HCPCFC Administrative Budget

6. Expenditure Grand Total (see Expenditure Grand Total on the Invoice form.)

Enter the sum of the Total Personnel Expenses, Operating Expenses, and Indirect Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the Invoice form.

B. Source of Funds.

1. State

Enter the amount of State General Funds expended for this quarter in Column 1.

The Total State General Funds in Column 1 is the sum of the amounts in Columns 2 and 3.

2. Federal

Enter the amount of Federal Funds (Title XIX) expended for this quarter in Column 1.

The Total Federal Funds (Title XIX) is the sum of the amounts in Columns 2 and 3.

a. Enhanced State/Federal (Column 2, Source of Funds)

Multiply the Expenditure Grand Total line of Column 2, by 25 percent. Enter this amount in the State Funds line of Column 2.

Subtract the amount of State Funds in Column 2, from the Expenditure Grand Total line of Column 2. Enter this amount in the Federal Funds (Title XIX) line in Column 2.

b. Non-enhanced State/Federal (Column 3, Source of Funds)

Multiply the Expenditure Grand Total line of Column 3, by 50 percent. Enter this amount in the State Funds line of Column 3.

Subtract the amount of State Funds in Column 3, from the Expenditure Grand Total line of Column 3. Enter this amount in the Federal Funds (Title XIX) line in Column 3.

c. Expenditure Grand Total (Column 1, Source of Funds)

Enter in Column 1 the total of Column 2 and Column 3, in the County/City Funds line.

Enter in Column 1 the total of Column 2 and Column 3, in the Federal Funds (Title XIX) line.

NOTE: The totals of funding amounts entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the Expenditure Grand Total line.

C. Certification and Signatures

Enter the name and telephone number of the staff person responsible for preparing the HCPCFC Quarterly Administrative Expenditure Invoice form.

The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

NOTE: An original signature is required, signature stamps are not acceptable.

III. Instructions for Preparation of Child Health and Disability Prevention (CHDP) Program Foster Care Quarterly Administrative Expenditure Invoice

In order to receive reimbursement for the CHDP Program Foster Care expenditures, the Quarterly Foster Care Administrative Expenditure Invoice must be prepared in accordance with the following instructions. A sample CHDP Foster Care Quarterly Administrative Expenditure Invoice form is included.

The CHDP Foster Care Quarterly Administrative Expenditure Invoice (County/City Match) instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the Invoice form. Local county and city Child Health and Disability Prevention Programs administering the CHDP Foster Care Administrative Budget (County/City Match) are reimbursed for the actual administrative costs according to the amount of County/City Funds and Federal Funds (Title XIX) on the invoice form. General information about Children's Medical Services Quarterly Administrative Invoices is on page 235, Section 6, Plan and Fiscal Guidelines Manual.

The CHDP Foster Care Administrative Budget (County/City Match) is an optional budget to fund staff working in support of children and youth in out-of-home placement or foster care. Local county/city funds may be matched with Federal Funds (Title XIX) for this budget. No State General Funds are used in this budget or included on the CHDP Foster Care Administrative Expenditure Invoice form.

A. Category/Line Item

1. Total Personnel Expense (see I. Total Personnel Expense on the Invoice form.)

Enter the total amount of Personnel Expense for the quarter in Column 1. This amount is the total amount for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

Enter the total amount of county/city and federal funds at the enhanced percentage in Column 2.

Enter the total amount of county/city and federal funds at the non-enhanced percentage in Column 3.

The amount of enhanced and non-enhanced percentages is calculated using completed time study documents and other applicable documentation.

2. Total Operating Expense (see II. Total Operating Expense on the Invoice form.)

Enter the total amount of operating expenses for the quarter in Column 1.

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Enter the total amount of enhanced operating expense in Column 2.

Enter the non-enhanced operating expense in Column 3.

NOTE: Only travel and training expenses may qualify as operating expense for enhanced funding, and only when claimed by an Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. Total Capital Expense (see III. Total Capital Expense on the Invoice form.)

Enter the total amount capital expenses for the quarter on this line in Column 1 and Column 3. The definitions of equipment and prerequisites for reimbursement are found on page 121, Section 6 of the Plan and Fiscal Guidelines Manual.

4. Total Indirect Expense (see IV. Total Indirect Expense on the Invoice form.)

Enter the total amount of indirect expenses for the quarter on this line in Column 1 and Column 3.

5. Total Other Expense (see V. Total Other Expense on the Invoice form.)

Enter the total other expense on this line in Column 1 and Column

6. Expenditure Grand Total

Enter the sum of the Total Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses and Other Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the Invoice form.

B. Source of Funds

1. County/City Funds

County/city expenditures must meet the Federal Funds (Title XIX) funding match requirements to obtain this reimbursement. The county/city matching funds are not reimbursed but must be shown on the invoice.

2. Federal Funds (Title XIX)

a. Enhanced Funds

Multiply the Enhanced Expenditure Grand Total amount (Column 2) by 75 percent. Enter the amount on the Federal Funds (Title XIX) line, Enhanced, in the Source of Funds section.

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b. Non-enhanced Funds

Multiply the Non-enhanced Expenditure Grand Total amount (Column 3) by 50 percent. Enter this amount on the Federal Funds (Title XIX) line, Non-enhanced, in Source of Funds section.

c. Total Funds

Add Columns 2 and 3 together for the Federal Funds (Title XIX) line and enter the total in Column 1, Total Funds.

C. Certification and Signatures

Enter the name and telephone number of the staff person responsible for preparing the Foster Care Administrative Expenditure Invoice form.

The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

NOTE: An original signature is required, signature stamps are not acceptable.

Quarter ending: _____
month/date/year

HPCFC Quarterly Administrative Expenditure Invoice

Fiscal Year _____

County/City Name: _____

Column	1	2	3
Category/Line Item	Total Invoiced (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expense			
II. Total Operating Expense			
III. Total Capital Expense			
IV. Total Indirect Expense			
V. Total Other Expense			
Expenditure Grand Total	\$0	\$0	\$0

Column	1	2	3
Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
State Funds	\$0	\$0	\$0
Federal Funds (Title XIX)	\$0	\$0	\$0
Expenditure Grand Total	\$0	\$0	\$0

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

_____ Prepared By	_____ Date	_____ Phone Number
_____ CHDP Director or Deputy Director (Signature)	_____ Date	_____ Phone Number

Quarter ending: _____
month/date/year**CHDP Foster Care Quarterly Administrative Expenditure Invoice**

Fiscal Year _____

County/City Name: _____

Column	1	2	3
Category/Line Item	Total Invoiced (2 + 3)	Enhanced County- City/Federal (25/75)	Nonenhanced County- City/Federal (50/50)
I. Total Personnel Expense			
II. Total Operating Expense			
III. Total Capital Expense			
IV. Total Indirect Expense			
V. Total Other Expense			
Expenditure Grand Total	\$0	\$0	\$0

Column	1	2	3
Source of Funds	Total Funds Invoiced	Enhanced County- City/Federal (25/75)	Nonenhanced County- City/Federal (50/50)
County-City Funds	\$0	\$0	\$0
Federal Funds (Title XIX)	\$0	\$0	\$0
Expenditure Grand Total	\$0	\$0	\$0

Source County-City Funds: _____

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By	Date	Phone Number
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CHDP Director or Deputy Director (Signature)	Date	Phone Number
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